DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid, CHIP and Survey & Certification

September 21, 2010

Mr. Robert D. Hofmann
Secretary
Agency for Human Services
103 South Main Street
Waterbury, VT 05671-0204

Dear Mr. Hofmann:

We are pleased to inform you that Vermont's Choices for Care section 1115 demonstration extension request has been approved. Choices for Care continues as project number 11-W-00191/6 for the period October 1, 2010, through September 30, 2015. This approval is under the authority of section 1115(a) of the Social Security Act.

The Centers for Medicare & Medicaid Services (CMS) finds that the Choices for Care demonstration:

- Promotes the objectives of the Medicaid program and the Americans with Disabilities Act by creating an entitlement to home and community-based services for a group with the highest need for care. Experience gained through this demonstration paves the way for other States seeking to reduce the institutional bias of Medicaid;
- Institutes a person-centered planning process by matching services to participants' needs and choices according to a person-centered assessment and options counseling process;
- Contains participant protections, incorporated into the Special Terms and Conditions of Approval, to ensure the health and welfare of program participants and continuous improvement of the demonstration program; and,
- Contains an evaluation component that continues to measure the demonstration's effectiveness in expanding comprehensive home and community-based services and preventing the need for nursing facility care.

Approval of this demonstration (and the Federal matching authority provided for thereunder) is contingent upon the State's agreement to the enclosed special terms and conditions (STCs). The STCs also set forth in detail the nature, character, and extent of Federal involvement in this project. The STCs are incorporated in their entirety into this approval letter and supersede all previous STCs.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in this letter, shall apply to the demonstration. Subject to the approval of your protocol, as described in the special terms and conditions, the following waivers and costs not otherwise matchable are approved.

Under the authority of section 1115(a)(1) of the Act, waivers of the following provisions of the Act (and its regulations) are granted for a period of 5 years in order to carry out the demonstration consistent with the accompanying special terms and conditions:

1. Reasonable Promptness 1902(a)(8)
To allow the State to maintain a waiting list for high and moderate need individuals applying for nursing facility and home and community-based services. To allow the State to require applicants for nursing facility and home and community-based services to complete a person-centered assessment and options counseling process.

2. Comparability 1902(a)(10)(B)
To allow the State to provide nursing facility and home and community-based services based on relative need as part of the person-centered assessment and options counseling process for new applicants for such services; to permit the provision of services under the demonstration that will not otherwise be available under the State plan; to limit the amount, duration, and scope of services to those included in the participants' approved care plan.

3. Institutional Income and Resources 1902(a)(10)(C)(i)(III)
To allow the State to use institutional income and resource rules for the high and highest need groups of the medically needy in the same manner as it did for the terminated 1915(c) waiver programs subsumed under this demonstration. Additionally, this waiver permits the State to have a resource standard of $10,000 for high and highest need medically needy individuals who are single and own and reside in their own homes and who select home and community based services (HCBS) in lieu of institutional services.

4. Freedom of Choice 1902(a)(23)
To enable the State to restrict freedom of choice of nursing facility providers.

5. Direct Payments to Providers 1902(a)(32)
To permit payments for incidental purchases to be made directly to beneficiaries or their representatives.

Under the authority of section 1115(a)(2) of the Act, expenditures made by the State under the demonstration for the items identified below (which are not otherwise included as expenditures under section 1903 of the Act) shall, for a period of 5 years, be regarded as expenditures under the State's title XIX plan:

1. Expenditures for HCBS for elderly and disabled adults, with income up to 300 percent of Supplemental Security Income payment level and resources up to $10,000, who do not meet the demonstration's clinical criteria for long-term care services, but are at risk of institutionalization.

2. Expenditures for medical assistance furnished to individuals who are receiving home and community based services, are not otherwise eligible under the approved State plan, who are found to be in the highest and high need groups, and whose income and resources are within the level to qualify to eligibility under the standard for institutionalized individuals.

3. Expenditures for medical assistance furnished to highest and high need groups of categorically needy individuals in order to have a resource standard of $10,000, but only for single individuals residing in their own homes and who select HCBS or other residential services over institutional care.

4. Expenditures for personal care services provided by participants' spouses.

5. Expenditures for cash allotments to provided to individuals, who are self-directing their services, for incidental purchases.

The following will not be applicable to individuals who are not otherwise eligible under the Medicaid State plan:

Cost-sharing and Premiums	1916
Retroactive Eligibility	1902(a)(34)

Your project officer is Ms. Jean Close, who can be reached at (410) 786-2804, or by e-mail at Jean.Close@cms.hhs.gov. Your project officer is available to answer any questions concerning the scope and implementation of the project described in your application. Communications regarding program matters and official correspondence concerning the project should be submitted to the project officer at the following address:

Centers for Medicare & Medicaid Services
Center for Medicaid, CHIP and Survey & Certification
Mail Stop S2-14-26
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Communications regarding program matters should be submitted simultaneously to Ms. Close and to Mr. Richard McGreal, Associate Regional Administrator for the Division of Medicaid and Children's Health in our Boston Regional Office. Mr. McGreal's contact information is as follows:

Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health Operations
JFK Federal Building, Rm. 2275
Boston, MA 02203

Should you have questions regarding this correspondence, please contact Ms. Barbara Coulter Edwards, Director, Disabled and Elderly Health Programs Group, at (410) 786-9493.

We extend our congratulations on this approval and look forward to working with you further during the course of the program.

Sincerely,

Cindy Mann
Director

Enclosures

Special Terms and Conditions of Approval

CENTERS FOR MEDICARE & MEDICAID SERVICES

NUMBER: 11-W-00191/6

TITLE: Vermont Choices for Care Section 1115 Demonstration
(formerly known as the Long-Term Care Plan)

AWARDEE: Vermont Agency of Human Services

The following are Special Terms and Conditions for the extension of the Choices for Care section 1115 demonstration (hereinafter "Demonstration") submitted on June 17, 2010. The extension is for the period October 1, 2010 through September 30, 2015. The Special Terms and Conditions are arranged in eight subject areas: General Program Requirements, General Reporting Requirements, Legislation, Assurances, Operational Protocol, and Attachments regarding General Financial Requirements, Monitoring Budget Neutrality, and a Summary Schedule of Reporting Items.

Letters, documents, reports, or other materials that are submitted for review or approval will be sent to the Centers for Medicare and Medicaid Services (CMS) Central Office demonstration project officer and the State representative in the CMS Regional Office.

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I. GENERAL PROGRAM REQUIREMENTS

1. Extension of the Demonstration. The head of the single State agency must submit to CMS a written request to extend the Demonstration at least 1 year prior to the expiration date of the current demonstration period. Without the submission of a request to extend, Vermont must begin phase down of the program 6 months prior to the end of the demonstration period.

2. Demonstration Phase-Out. The State may suspend or terminate this Demonstration in whole or in part at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State must submit a phase-out plan to CMS at least 6 months prior to initiating phase-out activities. Nothing herein must be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by emergent circumstances. The phase-out plan and extension plan are subject to CMS approval. If the project is terminated or any relevant waivers suspended by the State, FFP must be available for only normal close-out costs associated with terminating the Demonstration, including services and administrative costs of disenrolling participants.

3. **Enrollment Limitation During Demonstration Phase-Out.** If the State elects to suspend, terminate, or not renew this Demonstration as described in paragraph 6, during the last 6 months of the Demonstration, the enrollment of individuals who would not be eligible for Medicaid under the current Medicaid State plan must not be permitted unless the Demonstration is extended by CMS. Enrollment may be suspended if CMS notifies the State in writing that the demonstration will not be renewed.

4. State Right to Amend Demonstration. The State may amend this Demonstration in whole or in part at any time before the date of expiration. Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change, and may not be implemented until approved. Amendment requests will be reviewed by the Federal Review Team and must include, but are not limited to, the following:

a) An explanation of the public process used by the State to reach a decision regarding the requested amendment;

b) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality expenditure cap. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the approval period, using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment which isolates (by Eligibility Group) the impact of the amendment;

c) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

d) If applicable, a description of how the evaluation design must be modified to incorporate the amendment provisions.

5. CMS Right to Suspend or Preclude the Demonstration Implementation. CMS may suspend or preclude Federal Financial Participation (FFP) for State Demonstration implementation and/or service provision to demonstration enrollees whenever it determines that the State has materially failed to comply with the terms of the project, and/or if the implementation of the project does not further the goals of the Medicaid program.

6. State Right to Terminate or Suspend Demonstration. The State may suspend or terminate this Demonstration in whole or in part at any time before the date of expiration. The State will promptly notify CMS in writing of the reasons for suspension or termination, together with the effective date. If the Demonstration project is terminated by the State, CMS will be liable for only normal closeout costs. The State will submit a phase-out plan for CMS to review and consider for approval.

7. CMS Right to Terminate or Suspend. CMS may suspend or terminate the Demonstration in whole or in part at any time before the date of expiration whenever it determines, following a hearing, that the State materially failed to comply with the terms of the project. CMS must promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

8. Finding of Non-Compliance. The State does not relinquish its rights to challenge CMS' finding that the State materially failed to comply.

9. Withdrawal of Waiver Authority. CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or would promote the objectives of title XIX. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the demonstration, including services and administrative costs of disenrolling participants.

10. Federal Financial Participation (FFP). No Federal matching for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter.

II. GENERAL REPORTING REQUIREMENTS

(Attachment C provides a summary of the frequency of required reporting items)

11. Monthly Progress Calls. During the first 6 months of operation, CMS and the State will hold monthly calls to discuss Demonstration progress. After 6 months of operation, CMS and the State will determine the appropriate frequency of progress calls.

12. Quarterly & Annual Progress Reports. The State will submit quarterly progress reports that are due 60 days after the end of each quarter. The fourth quarterly report of every calendar year will include an overview of the past year as well as the last quarter, and will serve as the annual progress report. The CMS reserves the right to request the annual report in draft. The reports will address, at a minimum:

- a discussion of events occurring during the quarter (including enrollment numbers, lessons learned, and a summary of expenditures);
- a discussion of the State's progress in completing Quality Assurance and Quality Improvement Plan activities;
- notable accomplishments; and
- problems/issues that were identified and how they were solved.

13. Final Demonstration and Evaluation Report. At the end of the Demonstration period, a draft final report will be submitted to CMS for comments. CMS' comments shall be taken into consideration by the State for incorporation into the final report. The final report with CMS' comments is due no later than 180 days after the termination of the project.

III. LEGISLATION

14. Compliance with Federal Non-Discrimination Statutes. The State agrees that it must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

15. Compliance with Medicaid Law, Regulation, and Policy. All requirements of the Medicaid program expressed in law, regulation, and policy statement, unless specified otherwise in the STCs, waiver list, or expenditure authorities, or otherwise listed as non-applicable, must apply to the Demonstration.

16. Changes in the Enforcement of Laws, Regulations, and Policy Statements. All requirements of the Medicaid program expressed in Federal laws, regulations, and policy statements, not expressly waived or identified as not applicable in the award letter, will apply to the demonstration. To the extent that changes in the enforcement of such laws, regulations, and policy statements would have affected State spending in the absence of the Demonstration in ways not explicitly anticipated in this agreement, CMS will incorporate such effects into a modified budget limit for the demonstration. The modified budget limit would be effective upon enforcement of the law, regulation, or policy statement.

If the law, regulation, or policy statement cannot be linked specifically with program components that are or are not affected by the demonstration (e.g., all disallowances involving provider taxes or donations), the effect of enforcement on the State's budget limit will be proportional to the size of the demonstration in comparison to the State's entire Medicaid program (as measured in aggregate medical assistance payments).

17. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.

a) To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, a modified budget neutrality agreement for the Demonstration as necessary to comply with such change. The modified budget neutrality agreements would be effective upon the implementation of the change.

b) If mandated changes in Federal law require State legislation, the changes must take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

18. Changes in Federal Law Affecting Medicaid. The State will, within the time frame specified in law, come into compliance with any changes in Federal law affecting the Medicaid program that occur after the Demonstration award date. To the extent that a change in Federal law, which does not exempt State section 1115 demonstrations, would affect State Medicaid spending in the absence of the Demonstration, CMS will incorporate such changes into a

modified budget limit for the Demonstration. The modified budget limit will be effective upon implementation of the change in Federal law, as specified in law.

If the new law cannot be linked specifically with program components that are or are not affected by the demonstration (e.g., laws affecting sources of Medicaid funding), the State will submit its methodology to CMS for complying with the change in law. If the methodology is consistent with Federal law and in accordance with Federal projections of the budgetary effects of the new law in the State, CMS would approve the methodology. Should CMS and the State, working in good faith to ensure State flexibility, fail to develop within 90 days a methodology to revise the without-waiver baseline that is consistent with Federal law and in accordance with Federal budgetary projections, a reduction in Federal payments will be made according to the method applied in non-demonstration states.

19. State Plan Amendments. The State must not be required to submit title XIX State plan amendments for changes to demonstration-eligible populations covered solely through the Demonstration. If a population covered through the Medicaid State plan is affected by a change to the Demonstration, a conforming amendment to the appropriate State plan may be required, except as otherwise noted in these STCs.

20. Amending the Demonstration. The State must not implement changes to its program that require an amendment without prior approval by CMS. The State may submit an amendment for CMS consideration requesting exemption from changes in law occurring after the Demonstration award date. The cost to the Federal Government of such an amendment must be offset to ensure that total projected expenditures under a modified demonstration program do not exceed projected expenditures in the absence of the demonstration (assuming full compliance with the change in law).

21. Transition Plan. The State is required to prepare, and incrementally revise, a Transition Plan consistent with the provisions of the Affordable Care Act (ACA) for individuals enrolled in the Demonstration, including how the State plans to coordinate the transition of these individuals to a coverage option available under the ACA. The State must submit a draft to CMS by July 1, 2012, with progress updates included in each quarterly report. The State will revise the Transition Plan as needed.

IV. ASSURANCES

Acceptance of the Special Terms and Conditions of Approval constitutes the State's assurance of the following:

22. Preparation and Approval of Operational Protocol. Prior to service delivery under this demonstration, an Operational Protocol document, which represents all policies and operating procedures applicable to this Demonstration, will be prepared by the State and approved by CMS. The State acknowledges that CMS reserves the right not to approve an Operational Protocol in the event that it does not comply with the Special Terms and Conditions of Approval. *Requirements and required contents of the Operational Protocol are outlined in Section V of these Special Terms and Conditions.*

23. Person-Centered Planning Process. The State agrees to use a person-centered planning process to identify participants' and applicants' long term care needs and the resources available to meet these needs, and to provide access to additional care options, including the choice to use spouse caregivers, and to access a prospective monthly cash payment.

24. Adequacy of Infrastructure. Adequate resources for implementation, monitoring activities, and compliance to the Special Terms and Conditions of the Demonstration will be provided by the State. It is the goal of the Demonstration to serve more people, not fewer, by allowing and encouraging more home-based services, thus freeing up funds to serve more people. Through the State's 10 year plan, each year the State will add resources to the long term care system equivalent to a minimum of 100 additional Home and Community Based 'slots'. This indicates recognition would be required in order to accommodate a growing population.

25. Changes Resulting from Implementation of the Affordable Care Act (ACA). The State agrees to work with CMS to amend and implement, as necessary, any changes to the Demonstration that may result from implementation of ACA.

26. Changes to Level of Care Criteria. The State agrees to submit, for CMS review and approval, any current or proposed assessment instruments, policies, and procedures for determining the level of care for Demonstration participants and applicants.

27. Maintenance of Effort. The State agrees that annual expenditures for each year of the Demonstration shall be at least the same level of total combined Medicaid expenditures for nursing home services and for the two 1915(c) Waivers in place in Vermont during the base year for the demonstration, SFY 2003. This total figure is $120,236,519 per year. The State also agrees that the number of individuals fully served under the demonstration shall not decrease from the base year for the demonstration, SFY 2003. This total figure is 3201 participants per year.

28. Participant/Applicant Satisfaction and Waiting List Monitoring. Participants and applicants on waiting lists will be included in Demonstration Beneficiary Surveys, Quality Assurance/Quality Improvement activities and evaluation activities. The State agrees to report on the status of the waiting list and the status of participant/applicant satisfaction surveys,

Quality Assurance/Quality Improvement activities and evaluation activities during monthly progress calls between CMS and the State and in quarterly/annual reports.

29. Prioritization of Enrollment. The State is reserving a minimum of $1.7 million per year for provision of services to the Moderate Need group. Medicaid eligibles in the Moderate Need group must be served prior to expansion eligibles.

Should a waiting list for long-term care services develop, the State agrees that individuals entitled to long-term care services will be enrolled in the long-term care program before persons with lighter care needs, according to a prioritization process described in the Operational Protocol. Specifically, participants receiving services currently will continue to receive services before participants and applicants in the Highest Need group; participants and applicants in the Highest Need group will receive services before participants and applicants in the High Need group; and participants and applicants in the High Need group will receive services before participants and applicants in the Moderate Need group.

30. Restricting Choice of Providers. The State must provide access to nursing facility services to all Medicaid-eligible participants who meet the entitlement criteria established under the Demonstration and desire nursing facility placement. If the State pursues selective contracting, the State must submit, for CMS review and approval, a description of the process for selecting providers of nursing facility services and allocating nursing facility beds. The State must demonstrate that the process used to select providers of nursing facility services and to allocate Medicaid reimbursed, nursing facility beds is consistent with the requirements of section 1923 and is consistent with access, quality, and efficient and economic provision of care and services for all participants needing nursing facility services including special regard to access to services for individuals with complex long-term care needs.

CMS must review and approve readiness, before the State implements the selective contracting process. The CMS review will include, but is not limited to, a review of provider contracts, State legislative provisions, the public notice process, interviews with nursing facility providers, long-term care ombudsmen, Area Agencies on Aging, and participant advocates.

31. Eligibility/Enrollment. The State agrees to submit, for CMS review and approval, a revised and updated description of the eligibility groups included in for the demonstration (and eligibility exclusions).

The State agrees to continue to provide nursing facility services and Home and Community-Based Services (HCBS) to participants receiving these services prior to implementation of the Demonstration, in nursing facilities and through the 1915(c) Aged and Disabled and Enhanced Residential Care Home and Community-Based Services waiver programs. Participants will continue to maintain pre-demonstration service options if their level of care (using pre-demonstration criteria) remains the same or increases and their financial eligibility is maintained.

32. Self-Directed Supports. The State agrees to provide adequate resources to support participants in directing their own care. The support assures, but is not limited to, participants' compliance with laws pertaining to employer responsibilities and provision for back-up

attendants as needs arise. The State agrees to make background checks on employees available to participants, upon request, and provide guidance to participants on the results of checks

In addition, the State will provide adequate resources to support participants in securing and managing their personal care service providers and hours, including but not limited to the following self-directed supports:

A. Self-Directed Supports
   1. A fiscal agent/intermediary is available to all participants;
   2. Assistance in locating a provider;
   3. An assurance of the right to hire, fire and supervise the work of their providers; and,
   4. Consultants are available to participants to conduct assessments and annual reassessments, inform participants of their rights and responsibilities, monitor the quality of each participant's services, assist participants with learning their roles and responsibilities as "employer" and to understand the roles and responsibilities of their providers, act as points of contact if participants have questions or their care providers are unavailable, oversee the funds provided to participants, ensure that service allocations and services provided are consistent with the assessment and care plan, and make referrals to other community resources when participants' care needs exceed the scope of services or hours permitted under the demonstration program.

B. In addition to the above supports, the State agrees to the following:
   1. **Assistance of a Proxy**. This demonstration is designed to assist individuals who are capable of directing their own care. Individuals who are not capable of directing their own care will not be deliberately excluded from participating in the demonstration. Specifically, persons who require the assistance of others for care planning, or for whom authorization for care must be obtained from a proxy (e.g., a parent or legal guardian/representative) will not be excluded from program participation.
   2. **Supplant Services.** Cash payments provided under this demonstration program do not supplant informal care services that have routinely and previously been available to project participants. Such ongoing informal care services will be identified as a part of each participant's care plan.

33. Independent Advocate.

- An independent advocate or advocacy system is available to all participants and applicants in the demonstration program, including access to area agency on aging advocacy, legal services and the long-term care ombudsman.
- The Medicaid Fair Hearing process is available to all demonstration participants and applicants.

34. Quality Assurance and Quality Improvement (QA/QI). The Vermont Agency of Human Services will design and implement an overall QA/QI plan that effectively assures the health and welfare of program participants and applicants and continuous improvement in the

Demonstration program. The QA/QI plan will be consistent with the CMS Home and Community-Based Services Quality Framework and, at a minimum, include the following:

A. A plan for discovery, remediation, and improvement; and
B. A protocol for reviews, periodic home visits, and data collection; and plans to monitor implementation of the QA/QI plan.

35. Cost sharing/Co-payments. State agrees to maintain State Plan cost-sharing and co-payment provisions for the Highest Need and High Need groups. Should cost-sharing and co-payments be instituted for the Moderate Need (expansion group), the annual aggregate cost-sharing may not exceed five percent of annual household income.

36. Notification to Program Participants. The State agrees to notify Demonstration participants, including current eligibles receiving services through 1915(c) programs and nursing facility services, regarding eligibility changes to be implemented under the Demonstration, including, but not limited to, their enrollment into a section 1115 research and demonstration program. The notification to participants must meet the provisions of 42 CFR 431.210. Participants will be notified no later than 30 days prior to their transition to the Long Term Care Plan Demonstration. The State agrees to notify CMS 30 days in advance, before terminating the 1915(c) programs, in accordance with the requirements of 42 CFR 441.307.

37. Presumptive Eligibility. The State agrees to maintain current financial responsibility for the cost of services for participants found to be ineligible for Medicaid services and agrees not to request Federal financial participation for these expenditures.

38. Room and Board. The State agrees to submit only support services claims for Enhanced Residential Care and assures CMS that room and board will not be billed.

39. Reporting on Participants Receiving Community Rehabilitation and Treatment (CRT) Services and Moderate Need Participants. The State agrees to maintain systems to track and report expenditures for CRT Services to participants with severe and persistent mental illness and Moderate Need participants. Expenditures for CRT mental health services will be included under the budget neutrality agreement for Vermont's Global section 1115 demonstration. All other expenditures will be included under the budget neutrality agreement for the Choices for Care section 1115 Demonstration for participants who are also enrolled in the Choices for Care Demonstration. Expenditures for Moderate Need participants, eligible under the State plan, will be included under the budget neutrality agreement for the Global Demonstration except for certain home and community-based support services described under the Choices for Care Demonstration.

40. Evaluation and Monitoring Design. The State will conduct an evaluation of the impact of the Demonstration on participants and applicants. The State acknowledges the importance to CMS of an evaluation to the operation, quality improvement and possible modifications to innovative demonstration initiatives. The evaluation will, at a minimum:

- Identify a set of measures that may be the best predictors of individuals at risk for institutional placement;

- Determine the cost effectiveness of the overall long-term care program to furnish a comprehensive package of home and community-based services to individuals, based on their specific needs, as compared to the current system;
- Assess the effect of the Demonstration on delaying the need for nursing facility care;
- Determine the effect of the Demonstration and its policies on participant satisfaction;
- Determine the effect of the Demonstration and its policies on the array and amount of services available in the community;
- Determine the effect of the Demonstration and its policies on nursing facility census and acuity levels; and,
- Determine the effect of the Demonstration on the level of knowledge in the community with respect to long-term care resources, including Medicaid.

41. Interim Evaluation Reports. In the event the State requests to extend the Demonstration beyond the current approval period under the authority of section 1115(a), (e), or (f) of the Act, the State must submit an interim evaluation report as part of the State's request for each subsequent renewal.

42. Cooperation with CMS Evaluators. Should CMS conduct an independent evaluation of any component of the Demonstration, the State will cooperate fully with CMS or the independent evaluator selected by CMS. The State will submit the required data to the contractor or CMS as requested.

43. Budget Neutrality. The cost of services provided during the Demonstration will be no more than 100 percent of the cost to provide Medicaid services without the Demonstration.

44. Public Notice and Consultation with Interested Parties. The State must comply with the State Notice Procedures set forth in 59 FR 49249 (September 27, 1994) when any program changes to the Demonstration are proposed by the State.

V. OPERATIONAL PROTOCOL

45. Operational Protocol Timelines and Requirements. The Operational Protocol will be submitted to CMS no later than 60 days prior to program implementation. CMS will respond within 30 days of receipt of the protocol regarding any issues or areas for which clarification is needed in order to fulfill the Special Terms and Conditions, those issues being necessary to approve the Operational Protocol.

Subsequent changes to the Demonstration program and the Operational Protocol that are the result of major changes in policy or operating procedures, including changes to cost-sharing amounts or subsidy amounts, including adjustments for inflation, will be submitted for review by CMS. The State will submit a request to CMS for these changes no later than 45 days prior to the date of implementation of the change(s).

46. Required Contents of Operational Protocol:

a. Organization and Structural Administration. A description of the organizational and structural administration that will be in place to implement, monitor, and operate the demonstration, and the tasks each organizational component will perform. Include details such as a timeline for initiating tasks prior to and post implementation, including steps, estimated time of completion, and who will be responsible for the tasks.

b. Reporting Items. A description of the content and frequency of each of the reporting items as listed in the Special Terms and Conditions Section II and Attachments A and C of this document.

c. Implementation of the Patient Protection and Affordable Care Act (ACA). A description of how participants will be impacted by implementation of the ACA and how participants will be informed about any resulting changes. In addition, the State agrees to provide a description and timeline for implementing any changes to the Demonstration.

d. Reporting on Participants Receiving CRT Services or in the Moderate Need Group. A description of the systems for tracking and reporting on expenditures for participants enrolled in both the Global and Choices for Care Demonstrations. These participants receive Community Rehabilitation and Treatment Services (CRT) or Moderate Need services. Describe how expenditures for CRT or the Moderate Need group will be included under the budget neutrality agreement for the Global section 1115 demonstration. All other expenditures will be included under the budget neutrality agreement for the Choices for Care section 1115 demonstration for participants who are also enrolled in the Choices for Care demonstration.

e. Reporting on Participants Who Would be Included in PACE Vermont. A description of the plan for implementing the Program of All-inclusive Care for the Elderly (PACE) including a description of how program expenditures would be reported within the Demonstration.

f. Medicaid Fair Hearing. The State agrees to submit, for CMS review and approval, a protocol for resolving disagreements between the State and participants and applicants regarding eligibility for demonstration services. In addition, the State agrees to inform all Demonstration participants and applicants about the Medicaid Fair Hearing process. If Fair Hearing policies differ from non-demonstration Medicaid, then provide a description of the policies that will be in place in the demonstration and how the process will be monitored. Include a plan for informing participants and applicants about the steps of the Medicaid Fair Hearing policy.

g. Outreach/Marketing/Education. A description of the State's outreach, marketing, education, staff training strategy/schedule. NOTE: *All marketing materials must be reviewed and approved by CMS prior to use.* Include in the description:

- information that will be communicated to enrollees, participating providers, and State outreach/education/intake staff (such as social services workers and caseworkers, or contracted parties) regarding changes to clinical and financial eligibility standards;
- types of media to be used;
- specific geographical areas to be targeted for the Cash & Counseling Pilot and Adult Family Care program including the schedules for the public and participant information campaigns associated with the launching and continued program publicity;
- locations where such information will be disseminated;
- staff training schedules, schedules for State forums or seminars to educate the public;
- training materials for intake and eligibility staff regarding changes in determining eligibility for demonstration groups that include but is not limited to changes in resource limits;
- training materials, curriculum, and training schedule for State staff, case management agencies and Area Agencies on Aging regarding recruiting, identifying, and enrolling individuals, with special consideration to individuals who may qualify for the Moderate and High Need groups;
- policies and procedures regarding ongoing training for current and new staff following the initiation of the program;
- the availability of bilingual materials/interpretation services and services for individuals with special needs;
- training of consumers, advocates and the members of the public on the concepts of the Demonstration.

h. Notification to Program Participants. A plan that includes a timeline for notifying Demonstration participants, including current eligibles receiving services through 1915(c) programs and nursing facility services, regarding eligibility changes to be implemented under the Long-Term Care Plan demonstration, including, but not limited to, their enrollment into a section 1115 research and demonstration program.

i. Eligibility/Enrollment. A description of the population of individuals eligible for the Demonstration (and eligibility exclusions), including plans for population phase-in and 1915(c) program termination. A description of the population of individuals excluded from the Demonstration and served under the Global Demonstration. Describe the processes for the following and include the organization responsible for each of the processes:

- determining eligibility including methods for applying income and resource rules for the categorically and medically needy with limits up to $10,000, for individuals who are single and own their own home, and who select home-based services in lieu of institutional services or other residential care services;
- phasing-in changes in resource limits over the course of the demonstration and parameters for determining when the limits would increase, e.g., from $2,000 to $3,000, from $3,000 to $5,000 and from $5,000 to $10,000;
- determining income and resource disregards for the Moderate Need, expansion population;
- determining the clinical eligibility of individuals applying for services in the Moderate Need Group;
- determining participants' and applicants' level of care including assessment instruments, policies, and procedures;
- including mental status information in developing and carrying out service/treatment plans;
- conducting intake, assessment, enrollment, and disenrollment;
- conducting annual re-determinations of eligibility;
- determining the existence and scope of a Demonstration applicant's existing third party liability;
- implementing consumer-directed services including the number of participants to be served, service area, and expansion projections; and
- allocating a cash allotment to participants for self-directing services should this benefit prove feasible as a result of a pilot-program.

j. Enrollment Limit. Description of the enrollment limit and any process for revising the limit. Detailed description of how a waiting list will operate. Include any pertinent documentation or instructions for the waiting list as an attachment to the Protocol document. Include how individuals are selected from the waiting list to enter the program, how the list is maintained, the periodicity for assessing the changing needs of individuals on the waiting list, how the potential participants and applicants will be informed of their placement and standing on the list, how often they will be informed of their standing, and how the intake workers will be able to access and verify an individual's standing on the waiting list.

k. Restricting Providers. A description of the process for selecting providers of nursing facility services and allocating nursing facility beds. Describe how the process and criteria used to select providers of nursing facility services and to allocate Medicaid- reimbursed, nursing facility beds is consistent with the requirements of section 1923 and is consistent with access, quality, and efficient and economic provision of care and services. Provide a timeline for implementing the selection process including pre- and post-implementation activities.

l. Benefits. A complete description of Medicaid services covered under the Demonstration which includes general service categories and the specific services included therein.

- Description of the amount, duration and scope of services for which each Demonstration group will be eligible. Describe any interface with services provided through the State's Older American Act funds, Community Rehabilitation and Treatment (CRT), PACE Vermont, grant or State-only funds. Describe the services for which caregiver spouses or parents will be compensated and the mechanism for doing so. Include the criteria for determining who would receive services from caregiver spouses or parents.
- Descriptions of the person-centered planning process used in the developing of the plan of care and the individual budget; methodology for establishing the budget for plans of care; how purchasing plans are developed; procedures and mechanisms to be used to review and adjust payments for plans of care; services which will be cashed out; and, procedures for amending the description of services.

m. Quality. Description of an overall quality assurance monitoring plan that includes but is not limited to the following:

- quality indicators to be employed to monitor service delivery under the Demonstration and the system to be put in place so that feedback from quality monitoring will be incorporated into the program;
- roles and responsibilities of agencies charged with implementing the quality assurance monitoring plan;
- the mechanisms the State will utilize to assure that the care needs of vulnerable populations participating in this demonstration (i.e., the elderly and disabled) are satisfied, and that funds provided to these beneficiaries are used appropriately;
- the system the State will operate by which it receives, reviews and acts upon critical events or incidents and communicates with licensing and surveying entities, with a description of the critical events or incidents;
- supervision of case management staff related to monitoring participant health and welfare;
- quality monitoring surveys to be conducted, and the monitoring and corrective action plans to be triggered by the surveys;
- plans to report survey results, service utilization, and general quality assurance findings to CMS as part of the quarterly and annual reports;
- procedures for assuring quality of care and participant safeguards;
- procedures for insuring against duplication of payment between the demonstration; fee for service; Home and Community-Based Services waiver programs; the Global 1115 Demonstration; PACE Vermont, Older Americans Act Programs; grant programs; including fraud control provisions and monitoring;
- description of the State's Utilization Review (UR) process – nursing homes or other designated entity – to ensure objectivity/control of conflict of interest; and,
- plans for monitoring the administering of the Independent Living Assessment and procedures for addressing inconsistencies in administration, should these occur.

n. Self-Directed Supports: Education, Counseling, Fiscal Intermediary and Support Services. Descriptions of the following topics:

- the State's relationships and arrangements with organizations providing enrollment/assessment, counseling, training, and fiscal/employer agent services;
- the procurement mechanism, standards, scope of work and payment process for the fiscal/employer agent;
- procedures for ensuring sufficient availability of fiscal/employer agent services for participants who do not pass the mandatory test on employer responsibilities;
- procedures for mandatory testing of participants related to fiscal and legal responsibilities and training opportunities and support services available for participants of the demonstration who require assistance with their fiscal and legal responsibilities; and,
- the procedures that will govern how criminal background checks will be conducted on potential providers and how participants will be informed of the results of the criminal background checks.

o. Participant Protections for Self-Direction: A description of the State procedures and processes to assure that participant protections are in place. The description will include the following:

- procedures to assure that families have the requisite information and/or tools to direct and manage their care, including but not limited to employer agent services such as training in managing the caregivers, assistance in locating caregivers, as well as completing and submitting paperwork associated with billing, payment and taxation;
- provisions for emergency back-up and emergency response capability in the event those providers of services and supports essential to the individual's health and welfare are not available. While emergencies are defined and planned for on an individual basis, the State also has system procedures in place;
- procedures for how the State will work with individuals in the Flexible Choices option who expend their individualized budget in advance of the re-determination date to assure that services needed to avoid out-of-home placement and the continuation of the health and welfare of the individual are available; and,
- procedures for how decisions will be made regarding unexpended resources at the time of budget re-determination for Flexible Choices participants.

p. Financial Incentives. Plan for encouraging individuals to plan for their future long-term care needs via financial incentives for purchasing long-term care insurance. Description of the activities and timeline for accomplishing this objective.

q. Evaluation Design. A description of the State's evaluation design and a timeframe for implementing the design. The description will include the following (Attachment D provides an Evaluation Framework for submitting the Evaluation Design):

- discussion of the demonstration hypotheses that will be tested;
- outcome measures that will be included to evaluate the impact of the demonstration;
- financial impact data, including the number of people affected, the dollar value of services and other pertinent data.
- description of data to be utilized;
- description of methods of data collection;

- how the effects of the demonstration will be isolated from those of other initiatives occurring in the State;
- any other information pertinent to the State's evaluative or formative research via the demonstration operations; and
- plans to include interim evaluation findings in the quarterly and annual progress reports.

ATTACHMENT A

GENERAL FINANCIAL REQUIREMENTS

1. The State must provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS will provide FFP for allowable Demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in Attachment B (Monitoring Budget Neutrality for the demonstration).

2a. In order to track expenditures under this Demonstration, the State -must report Demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. All Demonstration expenditures subject to the budget neutrality cap must be reported on separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the Demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered or for which payments were made).The term, "expenditures subject to the budget neutrality cap," is defined below in item 2.c.

b. For each Demonstration year five separate Form CMS-64.9 WAIVER and/or 64.9P WAIVER reports must be submitted reporting expenditures subject to the budget neutrality cap. On the first form report the expenditures for the Highest Need Group. On the second form report the expenditures for the High Need Group. On the third form, report expenditures for the Moderate Need Group. On the fourth form, report expenditures for Demonstration eligibles also receiving CRT services under the VHAP 1115. On the fifth form, report Medicaid expenditures for PACE participants. All expenditures subject to the budget neutrality ceiling for demonstration eligibles must be reported. The sum of the expenditures, for all Demonstration years reported during the quarter, will represent the expenditures subject to the budget neutrality cap (as defined in 2. c.). The Demonstration Medicaid eligibility groups (MEGs), for reporting purposes, include the following names: Highest Need Group, High Need Group, Moderate Need Group, CRT Group, and PACE Group.

c. For the purpose of this section, the term "expenditures subject to the budget neutrality cap" must include all Medicaid expenditures on behalf of Demonstration eligibles. CRT for participants with severe, persistent mental illness would continue to be included in the Global 1115 demonstration and excluded from the Choices for Care 1115 demonstration. Services for the expansion group include case management, homemaker, adult day services and additional services as identified over the lifetime of the demonstration.

All expenditures that are subject to the budget neutrality cap are considered Demonstration expenditures and will be reported on Form CMS 64.9 WAIVER and/or 64.9P WAIVER.

The demonstration eligibles include the aged (age 65 years and older) and adults with physical disabilities (age 18 and through 64) who are in need of long-term care services (nursing facility, home and community-based services, PACE) or at risk of requiring nursing facility services. Services subject to budget neutrality would include State Plan services, home and community-based services, including Enhanced Residential Care, as defined under Vermont's 1915(c) programs which were subsumed into the Demonstration, PACE and nursing facility services. Services and eligibility groups are listed in Attachments E and F.

d. Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration, such as additional staff, equipment for those staff, space costs associated with those staff and contracts for technical assistance All administrative costs will be identified on the Forms CMS-64.10 WAIVER and/or 64.10P WAIVER.

e. All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2 year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the 1115 demonstration on the Form CMS-64 in order to properly account for these expenditures in determining budget neutrality.

f. The procedures related to this reporting process, report contents, and frequency will be discussed by the State in the Operational Protocol, to be included in the description in item 19.b. of Section V of this document.

3.a. For the purpose of monitoring the budget neutrality expenditure cap described in Attachment B, the State must provide to CMS on a quarterly basis the actual number of eligible member/months for the Demonstration eligibles as defined below. This information should be provided to CMS in conjunction with the quarterly progress report referred to in number 10 of Section III. If a quarter overlaps the end of one Demonstration year (DY) and the beginning of another, member/months pertaining to the first DY must be distinguished from those pertaining to the second. (Demonstration years are defined as the years beginning on the first day of the demonstration, or the anniversary of that day.) Procedures for reporting eligible member/months must be defined in the Operational Protocol (see Section V.).

b. The term, "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member/months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member/months.

c. The term "Demonstration eligibles" excludes unqualified aliens, and refers to adults (age 65 years and older) and adults with physical disabilities (age 18 and older) who meet

criteria for long-term care services in the community or in a nursing facility or who are at-risk of needing long-term care services. Specifically, demonstration eligibles include 1) participants in the 1915(c) Home and Community-Based Services Program for the Elderly and Disabled and the 1915(c) Enhanced Residential Care Program; 2) participants receiving long-term care services in a nursing facility; 3) participants meeting the demonstration's financial eligibility and long-term care clinical eligibility criteria for the Highest, High, and Moderate Need Groups; 4) participants meeting demonstration financial and clinical eligibility criteria and receiving CRT services under the Global section 1115 demonstration; and, 5) PACE participants.

4. The standard Medicaid funding process must be used during the Demonstration. Vermont must estimate matchable Medicaid expenditures on the quarterly Form CMS-37. In addition, the estimate of matchable Demonstration expenditures (total computable/Federal share) subject to the budget neutrality cap must be separately reported by quarter for each Federal fiscal year on the Form CMS-37.12 for both the Medical Assistance Program (MAP) and Administrative Costs (ADM). As a supplement to the Form CMS-37, the State will provide updated estimates of expenditures subject to the budget neutrality cap as defined in 2.c. of this Attachment. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State will submit the Form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. CMS will reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

5. The CMS will provide FFP at the applicable Federal matching rate for the following, subject to the limits described in Attachment B:

a. Administrative costs, including those associated with the administration of the Demonstration.

b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State Plan.

c. Net medical assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the Demonstration.

6. The State certifies that matching the non-Federal share of funds for the Demonstration are State/local monies. The State further certifies that such funds must not be used to match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of non-Federal share of funding are subject to CMS approval.

a. CMS will review the sources of the non-Federal share of funding for the Demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS must be addressed within the time frames set by CMS.

b. Any amendments that impact the financial status of the program must require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

7. Nothing in these STCs concerning certification of public expenditures relieves the State of its responsibility to comply with Federal laws and regulations, and to ensure that claims for Federal funding are consistent with all applicable requirements. The State must certify that the following conditions for non-Federal share of the Demonstration expenditures are met:

   a. Units of government, including governmentally operated health care providers, may certify that State or local tax dollars have been expended as the non-Federal share of funds under the Demonstration.

   b. To the extent that the State utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the State would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

   c. To the extent the State utilizes CPEs as the funding mechanism to claim Federal match for payments under the Demonstration, governmental entities to which general revenue funds are appropriated must certify to the State the amount of such tax revenue (State or local) used to satisfy Demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the State's claim for Federal match.

   d. The State may use intergovernmental transfers to the extent that such funds are derived from State or local tax revenues and are transferred by units of government within the State. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-Federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and State and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

8, The State will provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable time frame.

9. MSIS Data Submission. The State must submit its MSIS data electronically to CMS in accordance with CMS requirements and timeliness standards.

ATTACHMENT B

MONITORING BUDGET NEUTRALITY

The following describes the method by which budget neutrality will be assured under the Demonstration. The Demonstration will be subject to a limit on the amount of Federal Title XIX funding that the State may receive on selected Medicaid expenditures during the Demonstration period. The Special Terms and Conditions specify the aggregate financial cap on the amount of Federal Title XIX funding that the State may receive on expenditures subject to the budget neutrality cap as defined in 2.c. of Attachment A of this document. The budget neutrality cap will be the Federal share of the total computable cost of $1,801,126,948 for the 5-year renewal period of the Demonstration. The cap places the State at risk for enrollment and for Per Participant Per Month (PPPM) cost trends.

Impermissible DSH, Taxes or Donations
CMS reserves the right to adjust the budget neutrality ceiling in order to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through letters, memoranda or regulations. The CMS reserves the right to make adjustments to the budget neutrality cap if any health care related tax that was in effect during the base year, or provider related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

Changes Resulting from Implementation of the Medicare Modernization Act (MMA)
The State and CMS will develop a modified budget limit to respond to the implementation of the MMA. The modified budget limit would be effective upon enforcement of the law, regulation, or policy statement.

How the Limit will be Applied
The limit calculated above will apply to actual expenditures for demonstration, as reported by the State under Attachment A. If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to CMS. There will be no new limit placed on the FFP that the State can claim for expenditures for recipients and program categories not listed. If the Demonstration is terminated prior to the 5-year period, the budget neutrality test will be based on the time period through the termination date.

Expenditure Review
CMS will enforce budget neutrality over the life of the Demonstration, rather than on an annual basis. However, no later than 6 months after the end of each demonstration year, CMS will calculate an annual expenditure target for the completed year. This amount will be compared with the actual FFP claimed by the State under budget neutrality. Using the schedule below as a guide, if the State exceeds the cumulative target, they must submit a corrective action plan to CMS for approval. The State will subsequently implement the approved corrective action plan.

Year	Cumulative Target (Total Computable Cost)	Cumulative Target Definition	Percentage
Year 6	$331,150,864	Year -6 budget estimate plus	8 percent
Year 7	$657,107,837	Years 6 and 7 combined budget estimate plus	3 percent
Year 8	$1,005,997,160	Years -6 through 8 combined budget estimate plus	1 percent
Year 9	$1,389,894,902	Years 6 through 9 combined budget estimate plus	0.5 percent
Year 10	$1,801,126,948	Years 6 through 10 combined budget estimate plus	0 percent

ATTACHMENT C

SUMMARY SCHEDULE OF REPORTING ITEMS

Item	Timeframe for Item	Frequency of Item
Monthly Conference Calls	Prior to demonstration implementation and Post-implementation.	Monthly progress calls with CMS and the State.
Operational Protocol	Due to CMS 30 days after program approval, CMS comments 30 days after receipt, and State completion/CMS approval thereafter.	One Operational Protocol. Changes to the Operational Protocol must be submitted and approved by CMS.
Quarterly/Annual Progress Reports	Due to CMS 60 days after the end of a quarter.	One quarterly report per Federal Fiscal Year quarter during operation of the demonstration; the report for the fourth quarter of each year will serve as the annual progress report.
Final Report	Due to CMS 180 days after the end of the demonstration.	One final report.

ATTACHMENT D

EVALUATION FRAMEWORK

Section 1115 demonstrations are valued for information on health services, health services delivery, health care delivery for uninsured populations and other innovations that would not otherwise be part of Medicaid programs. CMS encourages States with demonstration programs to conduct or arrange for evaluations of the design, implementation and/or outcomes of their demonstrations. CMS also conducts evaluation activities.

CMS believes that all parties to demonstrations; States, Federal government, and individuals benefit from State conducted self-evaluations that include process and case-study evaluations – these would include, but not be limited to: 1) studies that document the design, development, implementation and operational features of the demonstration, and 2) studies that document participant and applicant experiences that are gathered through surveys, quality assurance activities, grievances and appeals, and in depth investigations of groups of participants and applicants and/or providers (focus groups, interviews, other). These are generally studies of short-term experiences and they provide value for quality assurance and quality improvements programs (QA/QI) that are part of quality assurance activities and/or demonstration refinements and enhancements.

Benefit also derives from studies of intermediate and longer-term investigations of the impact of the demonstration on health outcomes, self-assessments of health status and/or quality of life. Studies such as these contribute to State and Federal formation and refinements of policies, statutes and regulations.

States are encouraged to conduct short-term studies that are useful for QA/QI that contribute to operating quality demonstration programs. Should states have resources available after conducting these studies, they are encouraged to conduct outcome studies.

The following are criteria and content areas to be considered for inclusion in Evaluation Design Reports.

- Evaluation Plan Development - Describe how plan was or will be developed and maintained:
    - Use of experts through technical contracts or advisory bodies;
    - Use of techniques for determining interest and concerns of stakeholders (funding entities, administrators, providers, clients);
    - Selection of existing indicators or development of innovative indicators;
    - Types of studies to be included, such as Process Evaluations, Case-Studies and Outcome investigations;
    - Types of data collection and tools that will be used – for instance participant and provider surveys and focus groups; collection of health service utilization; employment data; or, participant purchases of other sources of health care coverage; and whether the data collection instruments will be existing or newly developed tools;

- Incorporation of results through QA/QI activities into improving health service delivery; and
- Plans for implementation and consideration of ongoing refinement to the evaluation plan.

- Study Questions – Discuss:
  - Hypothesis or research questions to be investigated;
  - Goals, such as:
    - Increase Access
    - Cost Effectiveness
    - Improve Care Coordination
    - Increase Family Satisfaction and Stability
  - Outcome Measures, Indicators, and Data Sources

- Control Group and/or Sample Selection Discussion:
  - The type of research design(s) to be included -
    - Pre/Post Methodology
    - Quasi-Experimental
    - Experimental
  - Plans for Base-line Measures and Documentation – time period, outcome measures, indicators and data sources that were used or will be used

- Data Collection Methods – Discuss the use of data sources such as:
  - Enrollment and outreach records;
  - Medicaid claims data;
  - Vital statistics data;
  - Provide record reviews;
  - School record reviews; and
  - Existing or custom surveys

- Relationship of Evaluation to Quality Assessment and Quality Improvement Activities– Discuss:
  - How evaluation activities and findings are shared with program designers, administrators, providers, outreach workers, etc., in order to refine or redesign operations;
  - How findings will be incorporated into outreach, enrollment and education activities;
  - How findings will be incorporated into provider relations such as provider standards, retention, recruitment and education; and
  - How findings will be incorporated into grievance and appeal proceedings.

- Discuss additional points as merited by interest of the State and/or relevance to nuances of the demonstration intervention.

ATTACHMENT E

Medicaid Eligibility Groups Covered Under Vermont Choices for Care Section 1115 Demonstration (Not An Exhaustive List)

Categorically Needy Medicaid Eligibility Groups

Mandatory Categorically Needy Coverage Groups

Medicaid Eligibility Groups	***Income and Resource Standards and/or Other Qualifying Criteria***	***Form CMS 64.9 or 64.9P Demonstration Group Reporting***
Individuals under age 21 eligible for Medicaid in the month they apply for SSI §1902(a)(10)(A)(i)(II)(cc)	*Income*: 100 percent of SSI *Resource*: $2,000 Age 18 up to age 21 Meet Demonstration clinical requirements	Highest, High, Moderate, or CRT
Individuals receiving SSI cash benefits §1902(a)(10)(A)(i)(II)	*Income*: 100 percent of SSI *Resource*: $2,000 individual $3,000 couple Meet Demonstration clinical requirements	Highest, High, Moderate, PACE, or CRT
Disabled individuals whose earnings exceed SSI substantial gainful activity level §1619(a)	*Income*: 100 percent of SSI *Resource*: $2,000 individual $3,000 couple Meet Demonstration clinical requirements	Highest, High, Moderate, PACE, or CRT
Disabled individuals whose earnings are too high to receive SSI cash benefits §1902(a)(10)(A)(i)(II)(bb); §1905(q); 1619(b)	*Income*: 100 percent of SSI *Resource*: $2,000 individual $3,000 couple Meet Demonstration clinical requirements	Highest, High, Moderate, PACE, or CRT
Pickle: individuals who would be eligible for SSI if Title II COLAs were deducted from income §503 of P.L. 94-566; §1939(a)(5)(E)	*Income*: 100 percent of SSI *Resource*: $2,000 individual $3,000 couple Meet Demonstration clinical requirements	Highest, High, Moderate, PACE, or CRT
Disabled widows and widowers §1634(b); §1939(a)(2)(C)	*Income*: 100 percent of SSI *Resource*: $2,000 individual $3,000 couple Meet Demonstration clinical requirements	Highest, High, Moderate, PACE, or CRT
Early widows/widowers §1634(d); §1939(a)(2)(E)	*Income*: 100 percent of SSI *Resource*: $2,000 individual $3,000 couple Meet Demonstration clinical requirements	Highest, High, Moderate, PACE, or CRT
Individuals ineligible for SSI/SSP because of requirements prohibited under	*Income*: 100 percent of SSI *Resource*: $2,000 individual $3,000 couple	Highest, High, Moderate,

Medicaid Eligibility Groups	***Income and Resource Standards and/or Other Qualifying Criteria***	***Form CMS 64.9 or 64.9P Demonstration Group Reporting***
Medicaid 42 CFR 435.122	Meet Demonstration clinical requirements	PACE, or CRT
Individuals receiving mandatory State supplements 42 CFR 435.130	*Income*: 100 percent of SSI *Resource*: $2,000 individual $3,000 couple Meet Demonstration clinical requirements	Highest, High, Moderate, PACE, or CRT
Individuals eligible as essential spouses in December 1973 42 CFR 435.131	*Income*: 100 percent of SSI *Resource*: $2,000 individual $3,000 couple Meet Demonstration clinical requirements	Highest, High, Moderate, PACE, or CRT
Institutionalized individuals who were eligible in December 1973 42 CFR 435.132	*Income*: 100 percent of SSI *Resource*: $2,000 individual $3,000 couple Meet Demonstration clinical requirements	Highest, High, Moderate, PACE, or CRT
Blind and disabled individuals eligible in December 1973 42 CFR 435.133	*Income*: 100 percent of SSI *Resource*: $2,000 individual $3,000 couple Meet Demonstration clinical requirements	Highest, High, Moderate, PACE, or CRT
Individuals who would be eligible except for the increased in OASDI benefits under P.L. 92-336 42 CFR 435.134	*Income*: 100 percent of SSI *Resource*: $2,000 individual $3,000 couple Meet Demonstration clinical requirements	Highest, High, Moderate, PACE, or CRT
Disabled adult children §1634(c); §1939(a)(2)(D)	*Income*: 100 percent of SSI *Resource*: $2,000 individual $3,000 couple Meet Demonstration clinical requirements	Highest, High, Moderate, PACE, or CRT
Qualified Medicare Beneficiaries §1902(a)(10)(E)(i); §1905(p)(1)	*Income*: 100 percent of FPL *Resource*: $6,000 single $9,000 couple Meet Demonstration clinical requirements	Highest, High, Moderate, PACE, or CRT
Specified Low-Income Medicare Beneficiaries §1902(a)(10)(E)(iii)	*Income*: >100 percent but =<120 percent of FPL *Resource*: $6,000 single $9,000 couple Meet Demonstration clinical requirements	Highest, High, Moderate, PACE, or CRT

Optional Categorically Needy Coverage Groups

Medicaid Eligibility Groups	***Income and Resource Standards and/or Other Qualifying Criteria***	***Expenditure and CMS 64 Eligibility Group Reporting***
Children under 21, (or at State option, 20, 19, or 18) who are under State adoption agreements §1902(a)(10)(A)(ii)(VIII)	*Income*: Title IV-E (§1931 Standard) *Resource*: Title IV-E (§1931 Standard; no resource test) Age 18 up to age 21 Meet Demonstration clinical requirements	Highest, High, Moderate, or CRT
Individuals who are eligible for but not receiving SSI or State supplement cash assistance §1902(a)(10)(A)(ii)(I)	*Income*: 100 percent of SSI *Resource*: $2,000 individual $3,000 couple Meet Demonstration clinical requirements	Highest, High, Moderate, PACE or CRT
Individuals who would have been eligible for SSI or State supplement if not in a medical institution §1902(a)(10)(A)(ii)(IV)	*Income*: 100 percent of SSI *Resource*: $2,000 individual $3,000 couple Meet Demonstration clinical requirements	Highest, High, Moderate, PACE or CRT
Special income level group: individuals who are in a medical institution for at least 30 consecutive days with gross income that does not exceed 300% of SSI income standard §1902(a)(10)(A)(ii)(V)	*Income*: 300 percent of SSI Federal benefit level *Resource*: $2,000 individual $3,000 couple Meet Demonstration clinical requirements	Highest, High, Moderate, PACE or CRT
Individuals receiving only an optional State supplement payment which may be more restrictive than the criteria for an optional State supplement under Title XVI §1902(a)(10)(A)(ii)(XI)	*Income*: based on living arrangement *Resource*: $2,000 individual $3,000 couple Meet Demonstration clinical requirements	Highest, High, Moderate, PACE or CRT
BBA working disabled group: Working disabled individuals who buy in to Medicaid §1902(a)(10)(A)(ii)(XIII)	*Income*: Up to 250 percent FPL *Resource*: In addition to SSI, disregard additional $3,000 for an individual and $4,000 for a couple Meet Demonstration clinical requirements	Highest, High, Moderate, PACE or CRT

Medically Needy Medicaid Eligibility Groups

Medicaid Eligibility Groups	***Income and Resource Standards and/or Other Qualifying Criteria***	***Expenditure and CMS 64 Eligibility Group Reporting***
Aged individuals who are ineligible as categorically needy §1902(a)(10)(C); §1905(a)(iii)	*Income*: $133^{1}/_{3}$ percent of §1931 income standard *Resource*: Family size 1: $2,000 Family size 2: $3,000 Each additional person: $150 Meet Demonstration clinical requirements	Highest, High, Moderate, PACE or CRT
Blind individuals who are ineligible as categorically needy §1902(a)(10)(C);§1905(a)(iv)	*Income*: $133^{1}/_{3}$ percent of §1931 income standard *Resource*: Family size 1: $2,000 Family size 2: $3,000 Each additional person: $150 Meet Demonstration clinical requirements	Highest, High, Moderate, PACE or CRT
Disabled individuals who are ineligible as categorically needy §1902(a)(10)(C); §1902(v)	*Income*: $133^{1}/_{3}$ percent of §1931 income standard *Resource*: Family size 1: $2,000 Family size 2: $3,000 Each additional person: $150 Meet Demonstration clinical requirements	Highest, High, Moderate, PACE or CRT

Expansion Groups Under §1115 Demonstration

Medicaid Eligibility Groups	***Income and Resource Standards and/or Other Qualifying Criteria***	***Expenditure and CMS 64 Eligibility Group Reporting***
Aged individuals over 65 and individuals over age 18 with physical disabilities who are not eligible as any State plan group but are at risk of institutionalization	At risk for LTC and in need of home and community-based services *Income:* up to 300% of the SSI/FBR. *Resources:* $10,000 (people with income below the limit and with excess resources may apply excess resources to income, up to the income limit) Meet Demonstration clinical requirements	Moderate Need
Categorically Needy Individuals receiving home and community-based services (HCBS) and residing in the community	Use institutional eligibility and post eligibility rules for individuals who would only be eligible in the institution in the same manner as specified under	Highest Need High Need

Medicaid Eligibility Groups	*Income and Resource Standards and/or Other Qualifying Criteria*	*Expenditure and CMS 64 Eligibility Group Reporting*
	42 CFR 435.217 and 435.726 and §1924 of the Social Security Act (the Act), if the State had 1915(c) waiver programs. Have a resource standard of $10,000, but only for single individuals residing in their own homes and select HCBS or other residential services over institutional care. Meet nursing facility level of care requirements.	
Medically needy receiving HCBS in the community	Use institutional eligibility rules for individuals who would not be eligible in the community because of community deeming rules in the same manner as if the State had §1915(c) waiver programs by waiving 1902(a)(10)(C)(i)(III). Additionally, this waiver permits the State to have a resource standard of $10, 000 for the highest need medically needy individuals who are single and own and reside in their own homes and who select home and community based services in lieu of institutional services Meet nursing facility level of care requirements.	Highest Need High Need
Categorically needy individuals receiving HCBS and residing in enhanced residential care facility	Use institutional eligibility and post eligibility rules for individuals who would not be eligible in the community because of community deeming rules in the same manner as specified under 42 CFR 435.217 and 435.726; and §1924 of the Act, if the State had §1915(c) waiver programs. Have a resource standard of $10,000, but only for single individuals residing in their	Highest Need High Need

Medicaid Eligibility Groups	*Income and Resource Standards and/or Other Qualifying Criteria*	*Expenditure and CMS 64 Eligibility Group Reporting*
	own homes and select HCBS or other residential services over institutional care. Meet nursing facility level of care requirements.	
Medically needy receiving HCBS in enhanced residential facilities.	Use institutional eligibility rules for individuals who would not be eligible in the community because of community deeming rules in the same manner as if the State had §1915(c) waiver programs by waiving the requirements specified at 1902(a)(10)(C)(i)(III). Additionally, this waiver permits the State to have a resource standard of $10, 000 for the high need medically needy individuals who are single and own and reside in their own homes and who select home and community based services in lieu of institutional services. Meet nursing facility level of care requirements.	Highest Need High Need
Categorically Needy PACE participants	Use institutional eligibility and post eligibility rules for individuals who would not be eligible in the community because of community deeming rules in the same manner as specified under 42 CFR 435.217 and 435.726; and §1924 of the Act, if the State had §1915(c) waiver programs. Have a resource standard of $10,000, but only for single individuals residing in their own homes and select HCBS or other residential services over institutional care. Meet nursing facility level of care requirements.	PACE

Notes:
1. SSI: Supplemental Security Income
2. SSP: State Supplementary Payment

3. COLAs: cost of living adjustments
4. FPL: Federal poverty levels
5. LTC: long-term care
6. PACE: Program of All-Inclusive Care for the Elderly
7. CRT: Community Rehabilitation Treatment
8. HCBS: home and community-based waiver
    #0163 Aged and Disabled 18 and Older
    #4186 Aged and Disabled Residing in Residential Care for Individuals 18 and Older

ATTACHMENT F
Services by Demonstration Group

All covered services are subject to medical necessity review. A complete description of covered services and limitations is contained in the Vermont approved title XIX State plan, the Choices for Care Operational Protocol, Vermont statutes, regulations, and policies and procedures.

State Plan Services	Highest Need	High Need	Moderate Need	CRT	PACE	Limitations
Inpatient Hospital Services	X	X		X		Any limitations on this service are described in the approved Title XIX
Outpatient Hospital Services	X	X		X		Any limitations on this service are described in the approved Title XIX
FQHC/RHC including ambulatory services offered by FQHCs	X	X		X		Any limitations on this service are described in the approved Title XIX
Laboratory/X-ray Services	X	X		X		Any limitations on this service are described in the approved Title XIX
Nursing Facilities Services for Individuals 21 Years or Older	X	X		X		Any limitations on this service are described in the approved Title XIX
EPSDT for Individuals Under 21						Not covered under Choices for Care
Family Planning Services and Supplies	X	X		X		Any limitations on this service are described in the approved Title XIX
Physician Services and Medical and Surgical Services of a Dentist	X	X		X		Any limitations on this service are described in the approved Title XIX
Home Health Services	X	X		X		Any limitations on this service are described in the approved Title XIX
Nurse Midwife Services	X	X		X		Any limitations on this service are described in the approved Title XIX

Pediatric/Family Nurse Practitioner	X	X		X		Any limitations on this service are described in the approved Title XIX
Other Medical/Remedial Care Provided by Licensed Practitioners and Recognized under State Law (podiatrist, optometrist, chiropractor, licensed clinical social worker, licensed mental counselor or licensed marriage and family therapist, psychologist, optician, hi-tech nursing, nurse practitioner, licensed lay midwife, chiropractor)	X	X		X		Any limitations on this service are described in the approved Title XIX
Clinic Services	X	X		X		Any limitations on this service are described in the approved Title XIX
Prescribed Drugs	X	X		X		Any limitations on this service are described in the approved Title XIX
Diagnostic, Screening, Preventive, and Rehabilitative Services	X	X		X		Any limitations on this service are described in the approved Title XIX
Private Duty Nursing Services	X	X		X		Any limitations on this service are described in the approved Title XIX
Eyeglasses						Not covered under the State Plan.
Dental Services	X	X		X		Any limitations on this service are described in the approved Title XIX
Prosthetic Devices	X	X		X		Any limitations on this service are described in the approved Title XIX
Physical and Occupational Therapies, and Services for Individuals with Speech, Hearing, and Language Disorders	X	X		X		Any limitations on this service are described in the approved Title XIX
Inpatient Hospital/Nursing Facility/ ICF Services for Individuals 65 and Older in IMD	X	X		X		Any limitations on this service are described in the approved Title XIX

ICF/MR Services						Not covered under Choices for Care
Inpatient Psychiatric Services for Individuals Under 21						Not covered under Choices for Care
Personal Care Services	X	X		X		Any limitations on this service are described in the approved Title XIX
Case Management	X	X		X		Any limitations on this service are described in the approved Title XIX
Respiratory Care for Ventilator Dependent Individuals	X	X		X		Any limitations on this service are described in the approved Title XIX
Primary Care Case Management	X	X		X		Any limitations on this service are described in the approved Title XIX
Program of All-inclusive Care for the Elderly (PACE)	X	X		X	X	Any limitations on this service are described in the approved Title XIX
Hospice	X	X		X		Any limitations on this service are described in the approved Title XIX
Transportation Services	X	X		X		Any limitations on this service are described in the approved Title XIX
Services Provided in a Religious Non-Medical Health Care Institution						Not covered under Choices for Care
Nursing Facility Services for Individuals Under Age 21						Not covered under Choices for Care
Emergency Hospital Services	X	X		X		Any limitations on this service are described in the approved Title XIX
Critical Access Hospital	X	X		X		Any limitations on this service are described in the approved Title XIX
Medicare Part A	X	X		X		For individuals enrolled in Choices for Care.

Medicare Part B	X	X		X		For individuals enrolled in Choices for Care.
Home and Community-Based Services						
Adult Day Services	X	X	X	X		Any limitation on this service are defined by Vermont rules and policies
Assistive Devices and Home Modifications	X	X		X		
Case Management	X	X	X	X		
Companion	X	X		X		Limited in combination with Respite Service
Homemaker	X	X	X	X		Excluded if participant receives Personal Care services since homemaker activities are includedamong Personal Care services
Incidental purchases paid out of cash allotments to participants who are self-directing their services	X	X				Limited to Flexible Choices participants who are self-directing their services
Nursing Overview	X	X				Limited to participants residing in Enhanced Residential Care
Personal Care	X	X		X		Includes assistance with ADLs and limited IADLs; laundry, meal preparation; medication management and non-medical transportation.
Personal Emergency Response System	X	X		X		
Respite Care	X	X		X		Limited in combination with Companion Service for individuals residing at home.
Social & Recreational Activities	X	X				Limited to participants residing in Enhanced Residential Care

Supervision	X	X				Limited to participants residing in Enhanced Residential Care
Transportation Services	X	X		X		Non-medical transportation. Limited to participants residing in Enhanced Residential Care. Included in Personal Care for individuals residing at home.